FAMILY PLANNING: A SURVEY OF CLINIC PATIENTS

By MARY G. ADAMS, B.Sc., M.B., and DENISE I. FULTON, M.B.
Belfast City Hospital, Belfast

Historical Background.

In the early centuries, when little was known about the true causes of disease, the population was limited by the very high infant mortality and by the short expectation of life, but according to Wingfield-Stratford (1942), "It was undoubtedly a fact that during the first forty years or so of the nineteenth century the people of this country bred children with such unprecedented rapidity as to swallow up the increase of the national dividend." Malthus, a philanthropic clergyman, came to the conclusion that every increase in wealth tended to be nullified by an increase in population and aroused much public controversy by his "Essay on the Principles of Population" (1798). He advocated late marriage as a means of controlling family size.

In 1800 world population figures were static, but people in England were becoming more and more aware of the burden and hardships of very large families and of the necessity for some form of birth control. Leaflets and tracts were secretly distributed during the early nineteenth century, giving instructions in coitus interruptus or in the use of a medicated sponge, as a means of family limitation, and in 1871 the Malthusian League was formed to encourage birth control. Unfortunately any effort made in the nineteenth century to encourage decent standards, to alleviate the worst effects of grinding poverty, or to improve the existing social order "was sure to start some expansively whiskered gentleman, primed with economics and respectability, to cast it out" (Wingfield-Stratford, 1942).

It was not until 1921 that the first birth control clinic was opened in London by Dr. Marie Stopes who, by her books and her Society for Constructive Birth Control, finally awakened public interest. Over three hundred other clinics have since been established in Great Britain.

In 1934 Dr. Marie Stopes came to Belfast, lectured to the Ulster Medical Society and to the Alpha Club, and addressed a public meeting. She advanced a loan for a house and equipment at The Mount, Belfast, to start a birth-control clinic. It was organised by a Ladies' Committee and a doctor, and employed a full-time trained midwife who was there five days a week. The nurse fitted the patients with contraceptives and a doctor came voluntarily once a week to see any difficult cases. However, there was little response, and very few patients were referred to the clinic. During the war the number of women attending rose gradually to about twelve new patients each week, mainly because of the number of wives of servicemen living in or near Belfast. Immediately after the war there was a steady decline in numbers, and the clinic only survived for a short period.

The birth-control clinic in the Royal Maternity Hospital was started about 1940 and medical cases referred by doctors are seen there on alternate Monday

afternoons. These patients are mainly referred from other hospital departments, and are women for whom a further pregnancy is considered inadvisable. They are fitted free of charge by a doctor employed by the Hospitals Authority.

In 1951 the "Women's Welfare Clinic" opened on one morning and one evening of each week in the extern department of Malone Place Hospital. This clinic was run voluntarily by women doctors and secretarial staff, who were helped by some of the nurses in the hospital, and as the number of patients increased more voluntary workers joined the staff. The clinic moved to the Belfast City Hospital when the building alterations at Malone Place Hospital began in 1959. The name "Women's Welfare Clinic" is a misnomer, and it is said that some doctors still think of it as a convenient source of orange juice and dried milk, but in recent years it seems to have become better known and is now entered as a family planning clinic in the list of clinics published by the Northern Ireland Hospitals Authority.

Another family planning clinic has recently been opened in Belfast. A general practitioner in the Newtownards Road area has generously lent her surgery on Tuesday afternoons to one of the clinic doctors. Patients seen here are charged a small fee when they first attend to cover expenses, but the doctor and secretarial staff work voluntarily. Patients from the Belfast City Hospital who find this clinic more convenient are transferred.

An Outline of Clinic Procedure.

The work of the family planning clinic in the Belfast City Hospital has been increasing every year and in 1960 of the 2,121 women who came to the clinic, 719 were new patients. Two clinics are held each week, one in the morning and one in the evening.

New patients make appointments by letter or by telephone, but there is now a waiting list of nearly three months (November, 1962), although about twenty appointments are made for each week. Patients are referred to the clinic mainly by friends or relatives, or by general practitioners, but a few are referred through other medical or social services (hospital departments, midwives, health and welfare visitors, marriage guidance councils or other family planning clinics in Great Britain).

Almost all the patients are given an occlusive diaphragm cap to be used with a chemical spermicide, but occasionally other forms of contraceptive have to be prescribed for those about to be married or for multiparous women with prolapse or other abnormality.

Clinic procedure here differs from that in most English family planning clinics where patients are initially given a practice cap and are asked to return for a further check before being prescribed their own cap and spermicide. Our patients are not asked to make two visits before getting supplies, but instead they are given more time than in most other clinics to understand and practise the fitting of a cap when they first attend, and this has advantages for women who come from long distances outside Belfast where no other clinics exist.

Further supplies can be obtained from the clinic when required, but every patient who is fitted with a cap is asked to return annually for a medical examination, and post-natal patients are refitted in four to five months, when involution is complete. Patients do not need an appointment for a return visit as re-examination and instruction do not take long, and they are encouraged to return at any time during clinic hours should they need further help or advice. In most English clinics patients are expected to return for a refit at six-monthly intervals. No figures have previously been produced here to compare results with those from other family planning clinics.

As the family planning clinic in the Belfast City Hospital is a recognised Hospitals Authority Clinic, no charge is made for consultation, and the patients only pay the cost of the supplies prescribed, usually about 12s. for a new patient.

The doctors and clerical staff work voluntarily, two nurses are paid recognised rates per hour and a secretary is now employed part-time. Any patient who is thought to be in poor circumstances is given supplies free of charge, while donations are accepted from those who can afford them.

Selection of Patients for the Survey.

No analysis of clinic records has ever been attempted, although the staff have often wondered if our methods were satisfactory, and if our results were worthwhile compared with those of other clinics in Great Britain. It was decided, therefore, to review a group of patients, to compare their social and marital status, and to find out how they were referred initially to the clinic. We particularly wanted to know why some patients, who only attended the clinic once, failed to return.

We chose patients referred to the clinic fairly recently, because those from earlier years might have been difficult to trace. Even this presented difficulties, because the clinic was moved from Malone Place to the Belfast City Hospital in 1959, and working conditions did not return to normal until the end of March, 1960, when better equipment was obtained and two nurses joined the staff again. All the new patients who first attended during the following three months, April, May, and June, were therefore chosen for the analysis. As attendances during the summer months were abnormal and the clinic was not open in August, those months were omitted, the new patients first seen in October, November, and December being added.

All those patients who came to the clinic for the first time during these six months in 1960, and who had not previously had birth-control instruction at any other clinic, were included. We believe this group to be representative of clinic patients seen under normal working conditions.

There were 412 new patients seen at the clinic in the survey period. Two hundred and thirty-one of these (56.1 per cent.) came from Belfast, and the remaining 181 patients came from outside the city, some from as far afield as Kilkeel, Banbridge, Ballymena, Castlerock, or even Londonderry. Only the 231 patients who lived in Belfast were included in the study because of the difficulties of visiting patients living outside the city. Some information was available from

the medical records, but the rest was obtained by a questionnaire or, where this failed, by a visit.

Classification of Patients in the Series into Selected Groups.

Ninety-four of the 231 patients (40.7 per cent.) came back to the clinic at least once after their initial visit, and these patients were presumed to be satisfied with this form of family planning and were called the *attenders*. One woman in this group became pregnant while using a cap, but this failure did not discourage her and she subsequently returned to the clinic.

The remaining 137 patients (59.3 per cent.) did not come back to the clinic for supplies or for their annual medical check, but seven of them were known to be leaving Northern Ireland soon after their initial visit. Seven other patients could not be fitted with caps owing to abnormalities such as cystocœle and rectocœle, or general loss of muscle tone; they were given other contraceptives and were not asked to return.

This left 123 patients who should have returned to the clinic—the group that interested us most. A letter enclosing a simple questionnaire was sent in 1962 to all these patients. Sixteen letters were returned undelivered, and 53 people (43.1 per cent.) replied. The homes of 54 patients, all those who failed to reply, were visited, and 12 more women were found to have left the area. The other visits were successful, and the patients seemed glad to see us and to discuss their problems. There were six patients who had not returned because of illness, and one woman had reached the menopause; as they did not require contraceptives, these seven patients were not included in any further study.

There remained 88 patients still living in Belfast who should and could have returned to the clinic, but failed to do so. These are classified in Table 1 and they have been divided into two groups—the *non-attenders* (patients who had temporarily stopped using contraception, and those who continued to use the recommended method but had not come back to the clinic), and the *defaulters* (patients who did not return because they were dissatisfied with this form of family planning).

Non-attenders (37 patients).

Fourteen patients had recently had a "planned" baby or were pregnant and two others were hoping to conceive. Twenty-one patients claimed to be using the method prescribed, many of them buying their own supplies or asking a friend to collect them from the clinic. Some did not realise that it was necessary to return annually for a medical check, in spite of the fact that each patient is given a card showing the date when she is due to return.

Defaulters (51 patients).

(a) *Pregnancies.* Seven patients became pregnant because they did not always use their caps, or because they had no spermicide and had failed to get more supplies. These were "accidental" pregnancies, not attributable to any technical failure of the recommended method of contraception. Two women were probably already pregnant when they came to the clinic. They were both fitted approximately three weeks after their last menstrual periods and were delivered between

38 and 39 weeks later. There were three "unplanned" pregnancies (3.4 per cent. of the 88 patients). These pregnancies occurred despite claims by the patients to have used the cap correctly. There was also one woman already mentioned in the "attender" group, who had an unplanned pregnancy. Hence there were four pregnancies owing to technical failure of the method in the group of 182 patients (2.2 per cent.). This compares favourably with results reported from other family planning clinics.

(b) *Disapproval.* Seventeen patients "disapproved" of this means of family planning. Six of them felt it was not a safe method of contraception, seven others found it inconvenient and unpleasant to use, and four said that they could not manage the cap properly.

TABLE 1.

REASONS GIVEN BY 88 PATIENTS WHO DID NOT RETURN TO THE CLINIC.

REASONS GIVEN FOR NOT RETURNING.	No.	PER CENT.
Non-attenders (37)—		
Pregnancy (14) or hoping to conceive (2)	16	18.2
Still using cap	21	23.9
Defaulters (51)—		
Pregnancy:		
"Accidental"	7	7.9
"Before fitting"	2	2.3
"Unplanned"	3	3.4
"Disapproval"	17	19.3
Discomfort	6	6.8
Difficult to attend	5	5.7
No valid reason	11	12.5
TOTAL	88	100.0

"Accidental" pregnancy = Not using method recommended.
"Unplanned" pregnancy = Using method recommended.

(c) *Discomfort.* Six patients complained that the cap caused discomfort. A patient should not normally feel a cap of the correct size which is properly fitted. Common causes of discomfort are constipation, incorrect size of cap, or a cap which is inserted in one of the fornices and causes pressure on the cervix. The discomfort found by these patients could probably have been relieved, had they returned to the clinic for further examination and instruction.

(d) *Difficult to attend.* Five patients found it too difficult to attend the clinic and two of these said they could not afford supplies. Perhaps these women should not have been asked to pay, but it is not always easy to estimate when a patient

needs financial help. It is hard to believe that a patient in poor circumstances would rather risk a further pregnancy than pay about £1 per annum for birth control. It seems more likely that these women viewed this method of contraception with scepticism and felt that money was wasted, or else had some deep sense of disapproval.

(e) *No valid reason.* There were eleven women who gave no real reason for not returning to the clinic, or just "couldn't be bothered" as one patient expressed it.

Six of the defaulters who were dissatisfied and gave up this method of family planning subsequently became pregnant. The defaulters as a group obviously included the patients so aptly described by Mary Stocks as "people with bewildered minds, clumsy fingers, shyness, fears, and fantasies."

Further study was limited to the 182 patients comprised by the attenders (94), the non-attenders (37), and the defaulters (51).

CLASSIFICATION OF THE PATIENTS ACCORDING TO HUSBAND'S OCCUPATION.

The husbands' occupations were classified from the entries on the medical cards when the patients registered, and from the standards of occupational skill defined by the Registrar General for England and Wales in "Classification of Occupations 1960," which gave five social classes:—

I. Professional, etc., occupations;
e.g., legal, medical, the arts.

II. Intermediate occupations;
e.g., schoolteacher, technical assistant.

III. Skilled occupations;
e.g., joiner, electrician, bus and lorry driver, machinist, plater, riveter.

IV. Partly skilled occupations;
e.g., bus conductor, postman.

V. Unskilled occupations;
e.g., labourer, docker.

As the series comprised a small number of patients, those in Classes I and II were combined. Unemployed persons were classified as VI, and were combined with social classes IV and V. Sometimes the description of the husband's work was vague and occasionally was not entered, but the figures in Table 2 give a general picture of the class of patient coming to the clinic.

Most of the patients' husbands (65.4 per cent.) belonged to Class III; these were the men who had raised themselves by a training from the unskilled status of labourers; 8.5 per cent. came from Classes I and II, and 26.1 per cent. came from Classes IV, V, and VI. The patients from the lower occupational classes seemed to have least success with this method of contraception. Only one patient from Classes I and II failed to continue the prescribed family planning, but 13 (30.2 per cent.) of the patients from the lower occupational classes, including four patients whose husbands were unemployed, gave up the method. Probably too few patients in these classes come to the clinic, and it is unfortunate that so many of those who do must be classed as defaulters.

TABLE 2.

COMPARISON OF DEFAULTERS WITH ALL PATIENTS IN THE STUDY GROUP ACCORDING TO OCCUPATIONAL CLASS OF HUSBAND.

CLASS OF OCCUPATION OF HUSBAND.	ALL PATIENTS.		DEFAULTERS.	
	No.	Per cent.	No.	Per cent. of all Patients in same class.
I and II	14	8.5	1	7.1
III	108	65.4	32	29.6
IV, V, and VI	43	26.1	13	30.2
Total	165	100.0	46	27.9
Services and Unclassified	17	—	5	—
TOTAL	182	—	51	28.0

All patients = attenders, non-attenders, and defaulters.

HOW DIFFERENT CLASSES OF PATIENT WERE REFERRED TO THE CLINIC.

Half of the patients (49.4 per cent.) were referred to the clinic by friends or relatives, and the remainder were referred by general practitioners (34.9 per cent.) or by other medical or social services (15.7 per cent.).

The general practitioners referred a high proportion of the patients from the lower social classes (28.1 per cent.), and of the few patients who came from Classes I and II the highest proportion was referred by other medical or social services (13.0 per cent.).

TABLE 3.

HOW DIFFERENT CLASSES OF PATIENT WERE REFERRED TO THE CLINIC.

CLASS OF OCCUPATION. OF HUSBAND.	BY WHOM PATIENT WAS REFERRED.					
	GENERAL PRACTITIONER.		OTHER MEDICAL OR SOCIAL SERVICES.		FRIEND OR RELATIVE.	
	No.	Per cent.	No.	Per cent.	No.	Per cent.
I and II	3	5.2	3	13.0	8	9.9
III	38	66.7	14	60.9	54	66.6
IV, V, and VI	16	28.1	6	26.1	19	23.5
Total	57	100.0	23	100.0	81	100.0
Services and not classified	5	—	5	—	7	—
TOTAL	62	34.9	28	15.7	88	49.4

There was no record of how four patients were referred to the clinic.

Age and Marital Status.

The ages of patients ranged from 18 to 46 years. There were twelve patients under 21 years of age and only one of them did not intend to return to the clinic; almost one-third (32.1 per cent.) of the fifty-three patients who were over 30 years of age gave up the recommended method of birth control.

Few pre-marital patients (4.9 per cent.) were seen at the clinic, but most women came within five years of marriage (43.1 per cent.), a further 32.1 per cent. came within ten years of marriage, but 6.6 per cent. had been married for more than fifteen years when they first came to the clinic. The remainder (13.3 per cent.) came within fifteen years of marriage. The Papers of the Royal Commission on Population (1949) showed that among those practising birth

TABLE 4.

Comparison of Defaulters with all Patients in the Study Group according to Family Size and to Husband's Occupation.

Number of Children	Class of Occupation. I and II				III			
	All Patients		Defaulters		All Patients		Defaulters	
0	6	(42.9%)	0	(0.0%)	17	(15.7%)	5	(4.6%)
1	4	(28.6%)	1	(7.1%)	20	(18.5%)	4	(3.7%)
2	2	(14.3%)	0	(0.0%)	35	(32.4%)	9	(8.3%)
3	1	(7.1%)	0	(0.0%)	19	(17.6%)	9	(8.3%)
4+	1	(7.1%)	0	(0.0%)	17	(15.8%)	5	(4.7%)
Total	14	(100.0%)	1	(7.1%)	108	(100.0%)	32	(29.6%)

Number of Children	Class of Occupation. IV, V, and VI				Not Known	Total		
	All Patients		Defaulters					
0	3	(7.0%)	1	(2.3%)	3	29	(15.9%)	
1	9	(20.9%)	2	(4.7%)	3	36	(19.8%)	
2	6	(14.0%)	1	(2.3%)	2	45	(24.7%)	
3	13	(30.2%)	3	(6.9%)	7	40	(22.0%)	
4+	12	(27.9%)	6	(14.0%)	2	32	(17.6%)	
Total	43	(100.0%)	13	(30.2%)	17	182	(100.0%)	

All patients = attenders, non-attenders, and defaulters.

Percentages are expressed on the number of patients in each social group.

Seventeen patients whose husbands were in the services, or who were not classified, are not included in the table of Social Classes.

control who were married between 1930 and 1934, 89 per cent. adopted control in the first five years of marriage; rather less than half of this proportion were using appliance methods.

Apart from the group who were married between 11 and 15 years, the proportion of clinic patients who gave up the recommended method rose according to the number of years they were married before they first attended the clinic.

CLASSIFICATION OF FAMILY SIZE ACCORDING TO HUSBAND'S OCCUPATION.

This is detailed in Table 4. Most patients had either two or three children when first seen; only twenty-nine women had no family. Seventeen patients had an average size of family of 5.6, and three of these had seven children. The 182 patients in the group had a total of 402 children, and the mean size of family was 2.2. In a survey of married women in general hospitals in England, the mean size of family of patients married between 1925 and 1934 was shown to range from 2.2 for those women with no unwanted children to 3.8 for those with unwanted children (Papers of the Royal Commission on Population, 1949).

A large proportion of the patients with four or more children belonged to the lower classes of occupation, and there appeared to be a greater tendency for the mothers with large families from Classes IV, V, and VI to give up this method of contraception than for the patients either in the higher social classes or with small families.

CONTRACEPTIVE PRACTICE AND FAMILY SIZE BEFORE REGISTRATION.

No reference to previous contraception is demanded on the clinic record cards, and inquiry about contraceptive practice was limited, therefore, to the patients interviewed in their homes, and to those who reattended since the survey began.

There were seventy-three patients, excluding those who had been married for less than six months, and fifty-four (74.0 per cent.) of them had used birth control before attending the clinic (Table 5). A survey of married women in

TABLE 5.

CONTRACEPTIVE PRACTICE AND FAMILY SIZE BEFORE REGISTRATION.

PREVIOUS CONTRACEPTION.	NUMBER OF CHILDREN. 0 or 1.	2	3	4+	TOTAL
Coitus Interruptus only	2 (10.0%)	6 (27.3%)	4 (26.7%)	3 (18.8%)	15 (20.6%)
Sheath only	5 (25.0%)	6 (27.3%)	3 (20.0%)	1 (6.2%)	15 (20.6%)
Chemicals only	0 (0.0%)	2 (9.1%)	2 (13.3%)	0 (0.0%)	4 (5.4%)
"Various"	5 (25.0%)	3 (13.6%)	4 (26.7%)	8 (50.0%)	20 (27.4%)
None	8 (40.0%)	5 (22.7%)	2 (13.3%)	4 (25.0%)	19 (26.0%)
TOTAL	20(100.0%)	22 (100.0%)	15 (100.0%)	16 (100.0%)	73 (100.0%)

Various = More than one method of contraception used.

general hospitals in England (Papers of the Royal Commission on Population, 1949) showed that 66 per cent. of the women married between 1935 and 1939 used some form of birth control, but only 37 per cent. used appliance methods (appliance methods include sheaths and chemical spermicides, as well as the cap).

In this group 27.4 per cent. of the patients had used more than one method of contraception, 20.6 per cent. had used only coitus interruptus, and a further 20.6 per cent. had used sheaths. Four patients had used chemical spermicides. There were sixty-seven patients with children, and 42 (62.7 per cent.) of them had at least one undesired pregnancy (41.8 per cent. had more than one) in an average of five and a half years of marriage. Half of the patients with at least four children had tried various methods of contraception, but 40.0 per cent. of those with no family or only one child, most of whom had been married for a short time, had not used any birth control.

Pregnancies since Registration.

Pregnancies in patients who had not returned to the clinic have already been discussed (see p. 52)—14 planned, 7 accidental, 3 unplanned, and 6 which occurred after the patients had given up the recommended method of birth control (the two patients who were probably already pregnant when they registered are not included). In addition to these, 13 of the attender group became pregnant within two years of their first visit—8 had planned to have babies, 4 had accidental pregnancies because they did not always use the cap and spermicide, and one, already referred to, had an unplanned pregnancy. Thus there were 43 pregnancies in the group of 182 patients (23.6 per cent.), occurring within two years of first registration, and 22 of these were planned. Only four of the remaining 21 patients had unplanned pregnancies attributable to technical failure of the cap (2.2 per cent. of the whole group); the others, representing 9.3 per cent. of the whole group, were either not using the full method recommended (6.0 per cent.) or were dissatisfied and had given it up (3.3 per cent.).

Discussion.

In the ten years since this family planning clinic was opened the demand for contraceptive advice has increased steadily and in 1960 2,121 women attended, one-third of them for the first time. In the survey period 56.1 per cent. of the new patients were from Belfast; most of those from outside the city came to the morning clinic (66.3 per cent.), and it is obvious that many women could not manage to make the long journeys to and from Belfast in the evening. As there is now a waiting list of three months for new patients, we feel that, in spite of the difficulty of recruiting more voluntary staff, the clinic should be opened more often, and other clinics should be started in the Province to fulfil the growing demand. Few patients seek advice for medical reasons as most of these are referred to the birth-control clinic in The Royal Maternity Hospital, but patients who wish to space their children or who do not want a larger family, sometimes for economic reasons, should be given the opportunity to obtain advice on family planning.

Of 231 patients living in Belfast, 18.2 per cent. stopped coming to the clinic because of illness, the menopause, or because they had moved from this area; 3.0 per cent. could not be fitted with caps and were given other contraceptives. Of the remaining 182 patients who could and should have returned to the clinic, 72.0 per cent. were satisfied apparently with this method of family planning, and 28.0 per cent. did not intend to continue (defaulters).

It is understandable why patients who had an unwanted pregnancy did not come back to the clinic, but the group of defaulters gave very varied reasons for not returning. A large proportion found the cap unpleasant, inconvenient, uncomfortable or too difficult to manage and a few were doubful of its value. Some patients had no real reason for discontinuing, but these women did not give us the impression of being less intelligent, more feckless, or from noticeably poorer homes than any of the others visited.

In the study of the percentage distribution of defaulters according to social class of husband, age, years of marriage, and family size, failure to continue seemed to occur most readily amongst the oldest patients and amongst those who had been married for over fifteen years. A high proportion of defaulters was observed in patients with large families from the lower social classes, which is unfortunate as they are the very people who most need help. We feel that extra time might usefully be given by the clinic staff to these mothers from poorer homes and, therefore, probably of poorer educational level, to ensure that they fully understand and are confident in the use of a cap; some of them might be encouraged to return a few weeks after their initial visit for further instruction and advice. We believe that too few patients from the lower social classes are referred to the clinic, and that many who are might be more successful if they came earlier in marriage, before being overburdened with too many children too closely spaced.

Some of the group of 182 patients planned a pregnancy within two years of registration (12.1 per cent.), but accidental pregnancies caused by human fallibility occurred in 6.0 per cent. and a small proportion (2.2 per cent.) had unplanned pregnancies despite their claims to have used the cap correctly. These results compare favourably with those of our analysis of contraceptive practice and family size before registration, in which 62.7 per cent. of the group of 73 patients had at least one undesired pregnancy, although most of them were using some form of birth control.

The "pill" has not so far been used in this clinic and we know that much has still to be done to make birth control simpler and surer, but results from this survey show that most patients who know of the clinic's existence are glad of its help and often travel long distances to obtain advice which they feel is important to the health and stability of their family life. In a population of approximately one and a half million, one-third of whom live in the Belfast area, there must be many more women who would welcome instruction in family planning.

SUMMARY.

A brief history of the development of family planning, and a description of the existing clinics in Belfast is given. A survey of a group of new patients first seen in 1960 was carried out to find how many women were still attending in 1962 and why some failed to return.

We wish to thank Dr. O. M. Anderson and all the clinic staff for their encouragement and co-operation. We are grateful to Professor J. Pemberton for his advice and comments and to the staff of the Department of Social and Preventive Medicine who duplicated the letters and questionnaires.

We are most grateful to Mrs. Vera Stewart for the time and trouble she has taken in preparing the manuscript of this report.

REFERENCES.

ROYAL COMMISSION ON POPULATION, Vol. I (1949). *Family Limitation.* London: Her Majesty's Stationery Office.

WINGFIELD-STRATFORD, E. (1942). *The History of British Civilisation.* London: Routledge.

REVIEW

DISEASE IN INFANCY AND CHILDHOOD. By Richard W. B. Ellis, O.B.E., M.A., M.D., F.R.C.P. Fourth Edition. (Pp. vii + 717; figs. 301. 60s.) Edinburgh and London: E. & S. Livingstone, 1963.

THIS edition follows quickly on the Third which was published in 1960, there having been translations into Spanish and Greek in the meantime. This is a most valuable and comprehensive textbook on disease in infancy and childhood. The illustrations are numerous and meet the demands of the text; they are of good quality and many are in colour. The chapter on congenital malformations is excellent and impressive. The author has justifiably retained adequate chapters on diseases which are becoming rare in this country such as rickets, congenital syphilis and tuberculosis. One presumes this is to appeal to those who practise in countries where these diseases persist; and for the same reason diseases not seen at home, such as kwashiorkor are excellently dealt with. This volume can be recommended without reservation to the post-graduate student and those who wish to bring their knowledge of paediatrics up to date whether for the purpose of examinations or because of their interest in diseases in infants and children. The author and publishers are to be congratulated.

F. M. B. A.